



FINANCIAL POLICY

We are committed to providing your child with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. _____ (initial)

We must emphasize that, as therapy providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy we extend to our families, all charges are your responsibility from the date services are rendered. _____ (initial)

You are responsible for checking with your insurance company regarding their coverage prior to starting regular therapy. You will be held responsible for charges for treatments rendered that your insurance denies, as detailed in your Therapy Services Agreement, including initial assessments. Depending on your individual insurance coverage, a deposit may be required before your course of therapy begins. _____ (initial)

Payment schedules will be issued based on insurance coverage estimates. Our estimates are subject to final approval by your insurance company; therefore, the amount due our facility is subject to change. _____ (initial)

I, the undersigned do agree that if my insurance does not pay my claim (for any reason) within 45 days, I will be responsible to pay the balance in full to Pediatric Therapy, Inc. within 15 days. My failure to do so will result in Pediatric Therapy, Inc. turning my account over to Collectech Diversified, Inc. for collection. The collection action will affect my credit rating. _____ (initial)

Unless prior arrangements have been made, all deductibles, and co-payments are due at the time of service. We accept Cash, Check, Visa, MasterCard, & Discover for your convenience. _____ (initial)

A \$15 fee will be charged for all returned checks. _____ (initial)

Please sign below if you have read, understand and agree to this Financial Policy:

X _____ Date: _____
Signature of Parent / Responsible Party

ASSIGNMENT OF BENEFITS

I authorize Pediatric Therapy, Inc. to bill my insurance for services they provide, and accept assignment of those benefits. I further authorize PTI to exchange any information pertaining to the patient necessary to insure payment by my insurance carrier.

Signature

Date